



Original communication

Implication of changes in Mental Health Laws in 2009–2010, a local Welsh experience

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ABSTRACT

Aims & method: This study seeks to explore the nature and extent of any increase, along with the impact of the increase on the workload of the MHA/DoLs practitioners.

Retrospective collection of data from MHA department and Guardianship/Deprivation of Liberty coordinators was followed by statistically evaluating the data.

Results: Over all, there was 56% increase in the use of the MHA over the previous year; the number of Guardianship orders increased by 85% while CTO increased by 825% and the number of tribunal appeals increased by 260%. Guardianship orders were 100% for S7 with an average length of 24 months. 36% of Guardianship orders lasted less than a year. In 2009/10 there were 98 DoLs authorisations. 70% of DoLs authorisations were supervised by the Local Authorities compared to 30% by the Local Health Board. Rate of DoLs authorisations per 100,000 populations was 42.3 for Local Authorities and 6.6 for Local Health Board. The average time consumed for the all new assessments amounted to 234.4 extra days per year. **Clinical implications:** The study shows increase in the volume of MHA, Guardianships and DoLs assessments. The amendments of the Act 2007 also attract an increase in the appeal process. The use of both the Act and the Deprivation of Liberty has increased workload for all involved practitioners.

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1. Introduction

The Mental Health Act (MHA) 2007 in England & Wales, most of which was implemented in November 2008, brought about changes to existing Mental Health legislation and also amended the Mental Capacity Act (MCA) 2005 to introduce the Deprivation of Liberty Safeguards (DoLs), which were implemented in April 2009. The major amendment to the Mental Health Act 1983 was the introduction of Supervised Community Treatment or Community Treatment Order (CTO), along with repeal of S25 Aftercare under Supervision (ACUS). The DoLs provide legal protection for people who lack mental capacity to decide on their residence and/or care and treatment needs, who are or about to become resident in a hospital or care home and for whom it is necessary to care in circumstances that amount to a deprivation of liberty.

The MCA is used when a person lacks capacity to decide on their treatment and care while detention under the MHA can be used for

a person who has capacity but does not consent to admission to hospital and/or to treatment or lacks capacity to consent, but is resistant to either admission to hospital or treatment. DoLs cannot be used where the person meets the criteria for detention under the MHA. Many of the early criticisms of MCA/DoLs arose from its interface with the MHA.¹

On the other hand, CTOs and guardianship provide treatment or care and supervision in the community where it cannot be provided without the use of compulsory powers. CTOs were introduced as a mechanism to enable individuals detained in hospital for treatment (under section 3 of the MHA or an equivalent Part 3 power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the responsible clinician (RC) has the power to set conditions on the patient, to which s/he is expected to adhere, and to recall the patient to hospital for up to 72 h (if the RC believes that the patient needs hospital treatment or if there is a risk of harm to the patient's health or safety or to others), which can be followed by release back into the community, an informal hospital admission or revocation of the CTO, resulting in a fresh period of detention in hospital for treatment.

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Guardianship powers allow the guardian (usually the Local Authority Social Services' Director) to require the patient to reside at a specific address, attend appointments for the purposes of care and/or treatment and to allow the guardian access when requested. Guardianship includes the power to take the patient to the place where s/he is required to reside and return him/her should s/he leave.

An increase in MHA-related activity would be expected, given the availability of new powers and duties.² This paper follows on from the previous publication and seeks to explore the nature and extent of any increase, along with the impact of the increase on the workload of MHA/DoLS practitioners.

2. Methodology

We have contacted the MHA department and Guardianship/Deprivation of Liberty coordinators and collected the data retrospectively followed by evaluating the data. The data were tabulated and figures were generated using excel. The data specifically included the number and characteristics of all assessments under MHA including Guardianship orders and Community Treatment Orders (CTOs), number of appeals, number of DoLS and time taken to complete each assessment during two years period 2008/9 and 2009/10. The percent increase was calculated by the subtracting the figures between 2009/10 and 2008/9, then dividing the outcome by the 2008/9 figure. The aim was to present the data as observed and compare it to the national data in Wales and England. Finally, we have asked all professionals involved (doctors, approved mental health professionals, Mental Health Act administrators) about the average time consumed to complete each assessment and calculated the total time for all assessments.

3. Results

3.1. MHA 2009–2010

100% were white British in ethnicity, of those 56% were males ($n = 72$). This reflects the ethnic demographic of the Welsh Valleys and local catchment area Table 1 show all assessments carried out in 2009/10 compared with 2008/9. Overall, there is 56% increase in the amount of assessments compared with the previous year. The number of CTO rose tremendously in 2009/10 ($n = 37$) compared with 4 in 2008/9 (825% increase). There was a significant increase in the use of section 5(2) (50% increase), section 136 (86% increase), section 135 (25% increase), section 2 (22% increase) and section 3 (76% increase).

Fig. 1 summarizes the appeal process. 105 tribunal appeals were requested in 2009/10 compared to 27 in 2008/9 (289% increase) and 37 managers hearings in 2010 compared to 29 in 2008/9 (200%

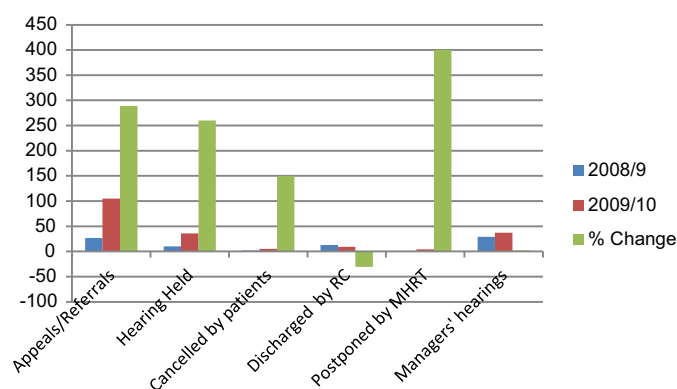


Fig. 1. MHA appeals.

increase). The hearings were held in 36 cases in 2009/10 compared to 10 cases in 2008/9 (260% increase). Less patients were discharged by the responsible clinicians in 2009/10 ($n = 9$) compared to 13 cases in 2008/9.

3.2. Guardianship orders in 2009–10

There was 85% increase in the number of guardianship cases at the end of the year (14 cases in 2009/10 compared with 2 in 2008/9). 79% of the new cases in the year were for men, but none of these were under Section 37 (following a conviction). Amongst continuing cases, 50% of those aged 45–64 years and 14% were aged over 75 years. The guardianship was conferred on the local authority in 100% of cases. The average length of cases closed in 2009–10 was 24 months. 36% of Guardianship cases closed had lasted less than a year.

In terms of primary mental health diagnosis: 14% of cases suffered dementia, 21.5% alcohol related cognitive impairment, 7% suffered brain injury, 36% suffered schizophrenia and 21.5% had learning disability. The guardianship was conferred on the local authority in all cases. In most cases the requirements of Guardianship included residence ($n = 13$), followed by gaining access ($n = 2$) and attendance ($n = 3$). 86% of individuals were white British in ethnicity.

3.3. Deprivation of liberty 2009/10

In 2009/10 there were 98 DoLS authorisations (Table 2). 70% of DoLS authorisations were supervised by the Local Authorities compared to 30% by the Local Health Board. Rate of DoLS authorisations per 100,000 populations was 42.3 for Local Authorities and 6.6 for Local Health Board. The average time between the request and instruction of best interest assessor (BIA) was 1 day while the average time between receipt of assessment and authorisation was 1.5 days. In 61% of cases the authorizations were granted with conditions. On average authorizations lasted 17 weeks and on average there were 8 authorizations per month.

3.4. Time consumed

The average total time consumed for the all new assessments amounted to 234.4 extra days per year (Fig. 2). Each MHA assessment/appeal took on average 5 h to complete by all professionals involved (two doctors, Approved Mental Health professional and Mental Health Act office administration) while DoLS took 15 h allowing for best interest assessment and examination by a doctor

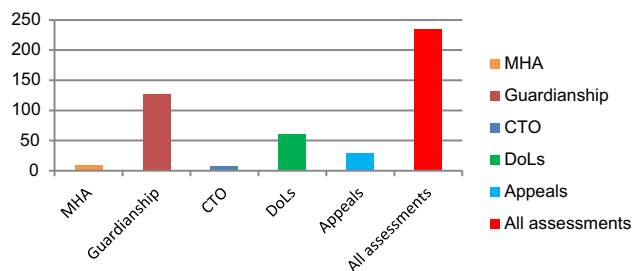
Table 1
All MHA assessments and % change.

	2008/9	2009/10	% Change
Section 2	100	122	22
Section 3	75	132	76
Section 37	1	5	400
Section 38	1	0	–100
Section 47/49	0	1	100
Section 135	4	5	25
Section 136	22	41	86.4
Section 5(4)	6	5	–16.7
Section 5(2)	28	42	50
Section 25	9	0	–100
CTO (Section 17 A)	4	37	825
Total	250	390	56

Table 2

Summary of all DoLS assessments compared with the rest of Wales.

	Number of referrals	Number of individuals	Population 18+ (thousands)	Number of authorisations	Proportion per 100,000 population
Local health board	30	15	227	15	6.6
All Welsh health boards	135	105	2370	75	3.2
Local authorities	70	46	227	45	42.3
All Welsh local authorities	412	344	2370	175	7.4

**Fig. 2.** Average total time to complete all assessments (days).

and Guardianship took 2 weeks to allow for authorisation by the Local Authority.

4. Discussion and conclusion

It is important to realise that this report is done in relation to the number of detentions and it does not reflect the vast number of assessments that did not result in an application being made.

This study shows 56% increase in the amount of assessments compared with the previous year. This has been mainly in relation to the use of CTO, section 5(2), section 136, section 135, section 2 and section 3. The increase in the use of Section 136 by the police may reflect their anxiety and defensiveness that lead to them exceeding the powers it gave them. This may reflect training issue. The increase in the use of the MHA has been accompanied by an increase in the proportion of these sections that are heard at an appeal.

This is the first report to indicate the average time consumed for the all new assessments that amounted locally to 234.4 extra days per year. This raises a concern on the impact of the changes in Mental Health Laws nationally in England and Wales.

In its first report the³ has reported that out of 1453 patients, around 25% of patients received care and treatment under the MHA. Of those, 261 people were made the subject of a CTO. The majority of people (93%) detained under the MHA are admitted to hospital under civil powers (*part II admissions*). Two thirds (66%) of part II admissions were subject to Section 2 of the MHA. In 2009/10 the CTO powers across Wales has far exceeded the estimates made originally. During 2009–10, 261 people were made the subject of a CTO, with an average of 25 each month. The number of patients detained under section 135 or 136 has risen by about 60%.

In England,⁴ the Care Quality Commission reported 45,755 detentions during the year 2009/10 compared to just over 15,000 patients in 2008/9 (excluding those detained on short-term holding powers = sections 5(2), 5(4), 135, 136). The number of people admitted directly from the community under civil powers (known as 'part 2 admissions') has risen. Also, the number of applications to the Tribunal rose sharply in comparison to the previous year. However, the percentage of hearings that resulted in the patient being discharged dropped to 12%. 4107 CTOs were made during 2009/10 with an average of 367 a month.

The increase in the use of Guardianship orders locally was consistent with the increase in Wales and England.^{5,6} The two weeks needed to complete Guardianship was a requirement by the Local Authorities, however, effort are being made to cut this down to less than a week.

The use of DoLS locally constitutes 18% of the total referrals in Wales. A wide disparity in practice was found in different parts of Wales. Factors contributing to this variation include: lack of training, knowledge and understanding among care staff and care providers, resistance to use of DoLS among care providers, health demographics of the local population which vary from valley to valley, the spread of the population specially that some counties are widespread over a big catchment area and also individual characteristics of health professionals in the different areas. Locally, we have invested money and time to ensure staff training over the past year which may explain part of the improvement in our figures compared to other parts in Wales. However, the number of authorisations was consistent with the rest of Wales. For England and Wales^{7,8} the total number of applications made was much lower than expected.

Despite the fact that the number of successful applications resulting in an authorisation to deprive a person of their liberty was lower than expected, a much higher percentage of applications than expected were successful (46.1% compared with the predicted 25.0%).

The above findings indicate a consistency in the implication of the changes in Mental Health laws across England and Wales.

It is very clear from this report that the amount of work has increased in the absence of any additional resources and that work has implication on staff work load and governance issues.

If on average each assessment needs 5 h to complete by all professionals and based on a working week of 40 h per week, the amount of extra work required in England and Wales would be 1,218,720 h for 243,744 assessments (MHA & DoLS) in the year 2009/10 amounting to 30,468 working weeks. As professionals on average work 40 weeks per annum taking away an annual or study leave, we would need 761.7 extra professionals to meet the extra work, of those at least 571 extra doctors in England and Wales.

Areas that need consideration are the need to liaison with Local Authorities to reduce the time needed for Guardianship orders; to ensure adequate and proper documentations about and comply with or understand capacity and consent requirements when assessing patient capacity to make a decision about their treatment; to take particular care to ensure that patients understand the implications of their detention and are clear about their rights, particularly in relation to their right of appeal and access to an advocate; and to ensure documentation of holistic, appropriate and detailed care plans that include risk management and contingency planning.

Over the coming years, there is a need to have a greater focus on CTO processes and the variation in its use across the country. Finally, the Government needs to be realistic in its expectation from individual organisations and that any agreed action plans need to be achievable and timely with the patient at its centre of attention.

Ethical approval

None.

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None.

Conflicts of interest

None.

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